

IDAHO COUNCIL ON CHILDREN'S MENTAL HEALTH

COMMUNITY REPORT
December 2004



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Introduction

Research indicates more than 17,000 children in Idaho live with a serious emotional disturbance (SED). Children affected by SED often have difficulty functioning at home, school, and in the community. Approximately 40 percent of these children and their families will need to access public services. Child serving agencies such as the Department of Health and Welfare, Juvenile Corrections, and Education serve a number of these children. However, children and families often need a broader array of services and supports than are found in traditional agencies. The system of care framework provides a holistic and coordinated approach to helping families affected by SED. In a system of care, families and professionals plan services and support centered on the strengths of the child and family, so that children with SED can thrive in their communities.

The Idaho Council for Children's Mental Health (ICCMH) is pleased to present the 2004 edition of the community report. This report contains an overview of the Idaho system of care, the ICCMH, Tribal Coordinating council, and regional and local councils. Reports from Departments of Education, Health and Welfare, Juvenile Corrections, State Mental Health Planning Council along with the Idaho Federation of Families for Children's Mental Health are included. As child-serving agencies and organizations continually work together, we are moving toward a statewide system of care.

System of Care Framework

System of Care describes a wide range of services and supports for families affected by serious emotional disturbance. It is supported by an infrastructure (Figure 1) and guiding principles. The infrastructure is a coordinated network of public and private agencies, advocacy and civic organizations. Organizations within the systems of care work together to assure that the needs of families and children are met. Services and supports in a system of care focus on the strengths of the child and family and are provided in the local community. Services and supports in a system of care can range from mental health services to participation in recreational programs.

Children's Mental Health councils are a vital part of our systems of care. Regional councils provide administrative oversight to local councils. Local councils empower families to make decisions, coordinate services and supports, and reduce the negative impact of mental health disorders on families. The councils are characterized by community partnerships.

Guiding principles for systems of care

- Families are full participants in service planning
- Services and supports are family centered
- Access to comprehensive services for children, including social, emotional, and educational
- Services should be provided in the least restrictive and normative environment
- Early identification and intervention is promoted
- Case management provides service coordination to meet changing needs of families and children
- Children with emotional disturbances are served in a manner that sensitive to cultural needs and differences

Reference: Building Systems of Care A Primer. Author: Sheila A. Pires (2002)

The cooperative agreement, “Building on Each Other’s Strengths,” supports system of care development in Idaho. The Department of Health and Welfare provides indirect and direct support for “Building on Each Other’s Strengths” including office space, and the required match from state general fund dollars appropriated to children’s mental health. The Idaho Council on Children’s Mental Health is the governing body for the cooperative agreement. Key areas of the agreement are technical assistance to community partners, evaluation of the system, infrastructure building, and a communications campaign. Goals for the cooperative agreement are based upon the guiding principles.

Supporting cooperative agreement activities

Orientation manual for council members

Learning opportunities calendar available at <http://facs-info.dhw.state.id.us/>

Annual Statewide Children’s Mental Health Conference

Technical Support for regional strategic planning meetings

Systems of Care newsletter

Interview protocol for national systems of care evaluation

Educational outreach for May is Mental Health month

Proposal for Tribal Coordinating Council

Bilingual documents

Local council evaluation

Goals for the Idaho System of Care

Goal 1: Develop system of care for children with serious emotional disturbance and their families.

We envision a parent driven, family focused, collaborative community care system for children with mental, emotional and behavioral disorders and their families, where parents are valued as being knowledgeable and are comfortable about accessing a full array of services in their own community. The array of services are individualized, coordinated and integrated to meet the family's cultural/linguistic and ethnic needs. No matter which point of agency access the parents enter, they are involved in the assessment, planning, implementation and evaluation of the treatment goals necessary to support their child and family.

Goal 2: Provide a broad array of mental health and other related services, treatments, and supports to children with SED and their families.

We envision the most appropriate services are available at the local level to meet the needs of children with SED and their families.

Goal 3: Evaluate the effectiveness of the system of care and its component services.

We envision parents, youth, service providers, and administrators all understand and value the importance of using program effectiveness data for making decisions leading to systems improvements.

Goal 4: Involve families in the development of the system and the services, and in the care of their own children.

We envision families, youth, system providers, and policy makers working together in teams with a focus on doing - whatever it takes - to continuously update and improve the system of care to meet the needs of children with SED and their families. Families are supported, encouraged, and acknowledged for their expertise and experience with their child and that they are respected for doing the best that they can in the efforts that they make with their children.

Goal 5: Use cultural competence approaches for serving children and their families from minority racial and ethnic populations in the community.

We envision that children identified as having SED and their families, throughout the state, will have equal access to high quality services delivered in an environment that respects and honors diverse cultural values and language differences

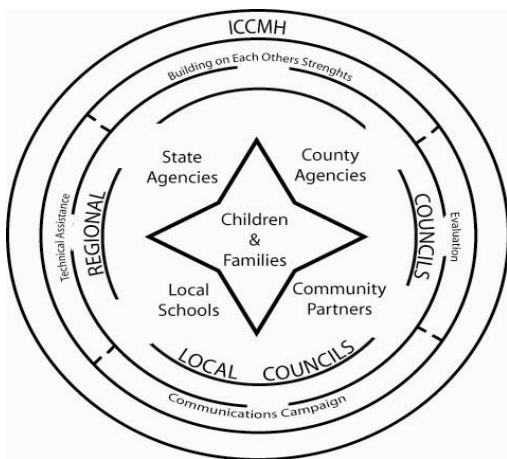


Figure 1: Infrastructure for Idaho System of care

Jim's Story

At age 11, Jim* was tired of school. His classmates bullied him; he was depressed, and begged his father to let him stay home. Diagnosed with Attention Deficit Hyperactivity Disorder, he was in special education classes.

Jim's father, Chuck*, didn't know what to do, so he called the comprehensive advocacy organization (COAD) in his area. They helped him advocate for his son and soon he had help from several agencies. Working with COAD, Jim's individual education plan improved.

An agency representative suggested Chuck and Jim visit a local children's mental health council. He was reluctant, and did so as a last resort. The council met with father and son to develop a plan based on their family strengths. Chuck told the council that Jim was doing better, but his self-esteem remained low. Part of the plan for Jim included counseling — and karate lessons. The council provided transportation.

Things at school began to improve. Representatives from Health and Welfare, Education, a case manager, Jim, and Chuck came together to discuss Jim's progress. It was a learning experience for everyone, as Chuck continued to drive the process. Most importantly, the plan was centered on Jim's individual needs.

Jim and Chuck are doing well as a family now. Jim is a new person, his comprehensive plan has improved his self-esteem, he makes eye contact with teachers, he is enthusiastic about school, and his fellow students don't bully him anymore.

Chuck now is a parent representative on his local council. To continue community partnerships, the local council sponsors a COAD parent advocacy training for parents like Chuck.

**names changed*

Federal Site Visit

As part of the cooperative agreement, the federal project officer conducted a site visit to review progress achieved in the project plan. The federal project officer's review team met with stakeholders and families served by the statewide system at all levels, and conducted reviews of structural, fiscal, organizational, and service delivery processes. Though not an extensive review, several areas of concern were identified and recommendations made to complete implementation of the system of care.

The key observations of the federal project officer include the lack of comprehensive strategic planning and system sustainability, standardized case management processes, uniform case documentation and files handling, and parents in partnership and leadership roles. The review team noted work was already underway in several of these areas, but encouraged an acceleration of effort so that the system's efficiency and growth would keep pace with the increasing numbers of families seeking services.

In addition to the federal site review, an evaluation was conducted by ORC Macro, primary contractor for the national systems of care evaluation. The ORC Macro review focused on a comparison of our system of care in relation to the Core Values and Guiding Principles of system of care. The final report is pending; however the exiting interview with the evaluators noted many of the same areas of concern as the federal project officer review team. The congruence of the two reviews provides clear guidance on areas where improvement directly translates into greater effectiveness for our system of care.

Local Council System of Care Baseline Assessment Summary

In late Fall, 2003, Local Evaluation Specialists (LES) visited council chairs to introduce themselves and to collect initial information about the status of each council's implementation of System of Care Principles. The protocol used by each LES provided a template of a generic system of care process model, and asked local council chairs and others to describe their council process in relation to the template.

The data received has been interpreted through the System of Care (SOC) Hallmarks (Pires, 2002). Each Hallmark was interpreted as consisting of a continuum of development, from emergent to accomplished. The Hallmarks are listed below:

- 1. Services driven by needs/preferences of child/family using their strengths.**
- 2. Family involvement is integrated into all aspects of service planning and delivery.**
- 3. The locus and management of services are built on multi-agency collaboration and grounded in a strong community base.**
- 4. A broad array of services and supports is provided in an individualized, flexible, coordinated manner and emphasizes treatment in the least restrictive, most appropriate setting.**

5. The services offered, the agencies participating, and the programs generated are responsive to the cultural context and characteristics of the populations that are served.

For analysis purposes, each Hallmark was related to one of the model steps of the SOC process. The five steps are:

1. Referral and Intake
2. Initial staffing
3. Service planning
4. Service provision and case review
5. Exit from council intervention

The following pages describe in detail where local councils were evaluated according to the Hallmarks. Below, is a summary of the evaluation. Two things are apparent: 1) All of the sites visited have moved to the emerging level of implementation. 2) Most sites are newly formed and are more advanced at the beginning stages of System of Care development (Referral and Intake) than at the later stages of development (Case Review and Exit).

Hallmark #1 Referral and Intake	Level of Current Application in Relation to Hallmark				
	Emerging		Developing		Accomplished
1. Services driven by needs/preferences of child/family using their strengths; Area of Focus:	Service provider without parent input brings case to council to discuss needs related to clinical diagnosis and on-going problems.		Service provider meets individually with parent to explain council and get permission to take case before council. Parent is invited to attend.		Service provider or other person and parent advocate prepares parent to visit council to discuss resources, needs and goals based on client wishes.
Current rating —	1	2	3	4	5
Baseline Mean (n=24)	1.....2.50.....5 Ý				

Hallmark #2 Initial Staffing	Level of Current Application in Relation to Hallmarks				
	Emerging		Developing		Accomplished
2. Family involvement is integrated into all aspects of service planning and delivery; Area of Focus:	Individual service provider works with family to elicit family needs/treatment needs.		Service providers collaborate to assess needs and brainstorm solutions; parents receive information but are not part of decision making process.		Parents lead discussion about needs and choose which actions will be supported by the council.
Current rating —	1	2	3	4	5
Baseline Mean (n=19)	1.....2.21.....5 Ý				

Hallmark #3 Planning	Level of Current Application in Relation to Hallmarks				
	Emerging		Developing		Accomplished
3. The locus and management of services are built on multi-agency collaboration and grounded in a strong community base.	Individual service providers plan services for clients in relation to agency requirements.		Individual service providers create a menu of services available for a particular client in relation to agency capabilities.		Parents, service providers, and community persons create services based on family/client needs and resources available from multiple sources.
Current rating —	1	2	3	4	5
Baseline Mean (n=18)	1.....2.0.....5 Ý				

Hallmark #4 Service provision and Case Review	Level of Current Application in Relation to Hallmarks				
	Emerging		Developing		Accomplished
4. A broad array of services and supports is provided in an individualized, flexible, coordinated manner and emphasizes treatment in the least restrictive, most appropriate setting. Area of Focus:	Client experiences services from individual agencies, each of which may have an individualized plan for the family. Service providers follow agency protocols in providing services.		Client experiences services from multiple agencies who share a common plan. Service providers coordinate services according to agency protocols.		Client experiences services in relation to goals set by family. Service providers blend available resources with community resources to meet on-going and evolving needs of clients.
Current rating —	1	2	3	4	5
Baseline Mean (n=16)	1.....2.13.....5 Ý				

Hallmark #5 Exit from Council	Level of Current Application in Relation to Hallmarks				
	Emerging		Developing		Accomplished
5. The services offered..are responsive to the cultural context and characteristics of the populations served.	Intervention has reduced symptoms as measured by individual agency guidelines.		Intervention has helped client be accommodated in multiple settings.		Intervention has helped client be successful in multiple settings.
Current rating —	1	2	3	4	5
Baseline Mean (n=5)	1.....1.4.....5 Ý				

The tables below indicate individual council status according to the Hallmarks. A next step will be to have councils self-assess and set goals around each of the Hallmarks. Councils are identified by number. The data is not comparative, but indicates trends in needs for support.

SOC Step #1: Referral and Intake Baseline Data

Hallmark 	Level of Current Application in Relation to Hallmarks				
	Emerging	Developing		Accomplished	
1. Services driven by needs/preferences of child/family using their strengths; Area of Focus: <u>Referral and Intake</u>	Service provider without parent input brings case to council to discuss needs related to clinical diagnosis and on-going problems.	Service provider meets individually with parent to explain council and get permission to take case before council. Parent is invited to attend.		Service provider or other person and parent advocate prepares parent to visit council to discuss resources, needs and goals based on client wishes.	
Current rating ____	1	2	3	4	5
1					
2				X	
3					
4			x		
5		X			
6	X				
7	X				
8			x		
9			x		
10			x		
11			x		
12					
13					
14					
15					
16					
17	X				
18	X				
19					
20					
21					
22			x		
23	X				
24			x		
25			x		
26			x		
27				X	
28					x
29		x			
30	X				
31			x		
32		x			
33		x			
34			x		
Total	6	4	11	2	1
Percent	25	17	46	8	4
Baseline mean (n=24)	2.50				

SOC Step #2: Initial Staffing

Hallmark 	Level of Current Application in Relation to Hallmarks				
	Emerging	Developing		Accomplished	
2. Family involvement is integrated into all aspects of service planning and delivery; Area of Focus: <u>Initial Staffing</u>	Individual service provider works with family to elicit family needs/treatment needs.	Service providers collaborate to assess needs and brainstorm solutions; parents receive information but are not part of decision making process.		Parents lead discussion about needs and choose which actions will be supported by the council.	
Current rating ——	1	2	3	4	5
1					
2				x	
3					
4		x			
5	X				
6	X				
7	X				
8	X				
9	X				
10			x		
11				x	
12					
13					
14					
15					
16					
17	X				
18	X				
19					
20					
21					
22					
23					
24					
25					
26					
27			x		
28				x	
29			x		
30	X				
31			x		
32		x			
33			x		
34			x		
Total	8	2	6	3	0
Percent	42	10	32	16	0
Baseline mean (n=19)	2.21				

SOC Step #3: Planning

Hallmark 	Level of Current Application in Relation to Hallmarks				
	Emerging	Developing		Accomplished	
3. The locus and management of services are built on multi-agency collaboration and grounded in a strong community base. Area of Focus: Planning	Individual service providers plan services for clients in relation to agency requirements.	Individual service providers create a menu of services available for a particular client in relation to agency capabilities.		Parents, service providers, and community persons create services based on family/client needs and resources available from multiple sources.	
Current rating —	1	2	3	4	5
1					
2			x		
3					
4		x			
5	X				
6	X				
7	X				
8	X				
9	X				
10			x		
11					
12					
13					
14					
15					
16					
17	X				
18	X				
19					
20					
21					
22					
23					
24					
25					
26					
27			x		
28					x
29		x			
30	X				
31		x			
32			x		
33		x			
34			x		
Total	8	4	5	0	1
Percent	44	22	28	0	6
Baseline mean (n=18)	2.0				

SOC Step #4: Service Provision and Review

Hallmark 	Level of Current Application in Relation to Hallmarks				
	Emerging	Developing		Accomplished	
4. A broad array of services and supports is provided in an individualized, flexible, coordinated manner and emphasizes treatment in the least restrictive, most appropriate setting.	Client experiences services from individual agencies, each of which may have an individualized plan for the family. Service providers follow agency protocols in providing services.	Client experiences services from multiple agencies who share a common plan. Service providers coordinate services according to agency protocols.		Client experiences services in relation to goals set by family. Service providers blend available resources with community resources to meet on-going and evolving needs of clients.	
Current rating —	1	2	3	4	5
1					
2				x	
3					
4				x	
5	X				
6	X				
7	X				
8	X				
9	X				
10			x		
11					
12					
13					
14					
15					
16					
17					
18					
19					
20					
21					
22					
23					
24					
25					
26					
27		x			
28					x
29	X				
30	X				
31		x			
32		x			
33		x			
34			x		
Total	7	4	2	2	1
Percent	43	25	13	13	6
Baseline mean (n = 16)	2.13				

SOC Step #5: Exit from Council

Hallmark 	Level of Current Application in Relation to Hallmarks				
	Emerging		Developing		Accomplished
5. The services offered, the agencies participating, and the programs generated are responsive to the cultural context and characteristics of the populations served.	Intervention has reduced symptoms as measured by individual agency guidelines.		Intervention has helped client be accommodated in multiple settings.		Intervention has helped client be successful in multiple settings.
Current rating ——	1	2	3	4	5
1					
2					
3					
4					
5					
6					
7					
8					
9					
10					
11					
12					
13					
14					
15					
16					
17					
18					
19					
20					
21					
22					
23					
24					
25					
26					
27					
28			x		
29	X				
30	X				
31					
32	X				
33	X				
34					
Total	4		1		
Percent	80		20		
Baseline mean (n = 5)	1.4				

Results from the survey are consistent with an emerging system of care. A secondary council survey will be conducted in the next six months.

Idaho Council for Children's Mental Health

The Idaho Council on Children's Mental Health (ICCMH) was formed in February 2001. The council's membership includes individuals with the authority to make policy decisions for the system of care. The Council is chaired by the Lt. Governor and has appointed members from the Governor's office, the Departments of Health and Welfare, Juvenile Corrections, and Education, as well as parents, advocacy groups, a county commissioner, and representatives of the legislature, judicial branch, children's mental health service providers, and regional councils. Membership also includes a member of the tribal coordinating council and a representative from the Hispanic community.

The ICCMH fosters the development and upholding of formal agreements between the collaborating child serving agencies. The ICCMH encourages all partners in a system of care to meet high standards of care, including standards for cultural competence, family involvement, and standards of practice that have been shown to be effective from research and evaluation studies. The Idaho Council on Children's Mental Health will monitor both the clinical and functional outcomes of children to ensure that services are making a positive contribution to the well-being of the children and their families using a participatory evaluation model. The ICCMH reviews the expenditure of funds within the cooperative agreement to assure they are used appropriately within the communities.

Accomplishments

Accomplishments for 2004 include establishment of the Tribal Coordinating Council. This council will coordinate services for children served by tribal and state agencies.

The "Children's Mental Health Services: A Parent's Guide" was updated for 2004. This guide provides information about the Idaho Federation of Families, child-serving agencies, responsibilities, services, and contact information. New information on crisis response protocols is included. The format of the guide was changed to include English and Spanish. Eighteen thousand guides were printed and are being distributed throughout the state.

The ICCMH also authorized regional strategic planning meetings and monthly regional chairs meetings. Initial strategic planning meetings were conducted from January to June 2004. Councils set priorities and goals for the year. As a result of the meetings, councils produced uniform statewide vision and mission statements for the councils, which were endorsed by the ICCMH. Monthly meetings have also encouraged goal setting and unity among the regional councils.

Regional/Local Council Vision and Mission Statements

Vision: Provide community-based services and supports that increase the capacity for children with serious emotional disturbance (SED) and their families to live, work, learn, and participate fully in their community.

Mission: Local councils provide strengths-based, comprehensive, culturally competent system of care for children with SED and their families. This includes sufficient financial support, regional trainings, local resource development, advocacy to State-level officials, and full-circle communication.

Challenges

Unfortunately, the current structure of public agency partners limits collaboration. Each partner has its own unique set of mandates, funding sources, legal limitations, and target populations. This compounds the number of barriers experienced by families and increases the pressure on community partners to develop less constrained alternatives. We struggle to see that our unique skills, abilities and resources can come together to help families and benefit entire communities.

Each partner is necessary to the establishment and success of the system of care, and yet each is limited in its ability to fully participate, producing a growing sense of frustration. We continue to have difficulty seeing each partner's place in the system and what they can bring to the system. There continues to be a "your child" "my child" mentality that is detrimental to system of care development. The system of care philosophy envisions that it is "our child. In a system of care, all partners bring resources together to children and families. There is no system of care without the participation of all partners.

When all partners fully participate, everyone wins. National studies of the system of care communities show improvement in academic functioning and attendance, as well as decreased involvement in juvenile justice. Both of these trends support education and juvenile justice agency goals.

While the ICCMH has specific responsibilities and functions as contained within the executive order, the ICCMH needs a clear vision and the means with which carry out that vision. The system has reached a point where, in order to move on and achieve a system of care, it has become necessary to explore ways to enhance the ICCMH structure and its ability to carry out its mandates. We need to look at this now, while the system is still young, before continuing frustrations threaten to diminish the level of effort provided by partners at all levels of the system.

Tribal Coordinating Council

The charter for the Tribal coordinating council was signed on August 27, 2004. The mission of this council is to develop culturally competent supports necessary for Indian children and families to receive help using the systems of care approach. Members of the

Kootenai Tribe of Idaho, Coeur d'Alene Tribe, Nez Perce Tribe, Northwestern Band of the Shoshone Nation, Shoshone-Piute Tribe, and the Shoshone-Bannock Tribes, are represented on the council. The Council works to bridge service gaps between local service providers and Tribal health/Social Services. Services that can be provided by local service providers are incorporated into the comprehensive plan for the child and family, and delivered in partnership with Tribal Health/Social Services. The tribal coordinating council along with other regional councils is a full partner in resource mapping and policy recommendations.

Regional Councils

There are seven regional councils located across the state. Each regional council serves a geographic area corresponding to one of the seven Department of Health and Welfare service delivery areas. Regional council membership varies based on the number of local councils in the geographic area and number of community partners willing to participate in the system of care. Typically, regional council members represent the community-based local councils, parents, child serving agencies, and other community partners such as businesses, faith-based organizations, and the judiciary.

Regional councils provide a critical link between community-based local councils and the ICCMH. Regional councils provide feedback to the ICCMH on successes and challenges being experienced at the community level in the development and implementation of Idaho's system of care. This is done through monthly regional council meetings. Regional chairs come together to examine challenges and concerns from their respective communities. The chairs refine issues and develop recommendations for possible adoption by the ICCMH. The regional councils also act as a conduit for the dissemination of statewide policies and plans affecting the statewide system of care to the local councils.

Regional councils receive a limited amount of flexible funding to support the regional council, local council, and family development. Community-based groups wishing to formally join in the statewide system of care are granted a charter from the regional council in their region.

Local Councils

Local councils connect community resources for children. Local councils are chartered collaborations at the local level with the purpose of extending the system of care to communities. There are more than 30 local councils statewide. Local councils work directly with families and children in their own communities to develop coordinated plans for services and supports. Councils may include participants from local school districts, the Department of Juvenile Corrections, the Department of Health and Welfare,

private providers, families of children with SED, and other community partners. Local councils in Elmore County, Horseshoe Bend, and Idaho City are being developed.

Councils facilitate community collaboration through training and council recruitment. Community collaboration of local councils has led to the development of a safe place for teens after school in one Region. Trainings sponsored by councils for community partners are increasing, and strategic planning is ongoing.

Trainings included topics such as “Youth with Mental Health Disorders: Who Are They and How Do We Work with Them?” by National speaker Lisa Boesky in Region 2. Attendance for this training was over 150 community members. Michael Clark, a national expert in strengths-based practice, provided training for council members in Region 1. Community outreach, including brochures, participation in health fairs, and local events bolstered community support in Region 7.

In addition to community outreach, some regional councils have created standardized forms, such as invoices. These standardized forms facilitate council expenditure processes in Region 4.

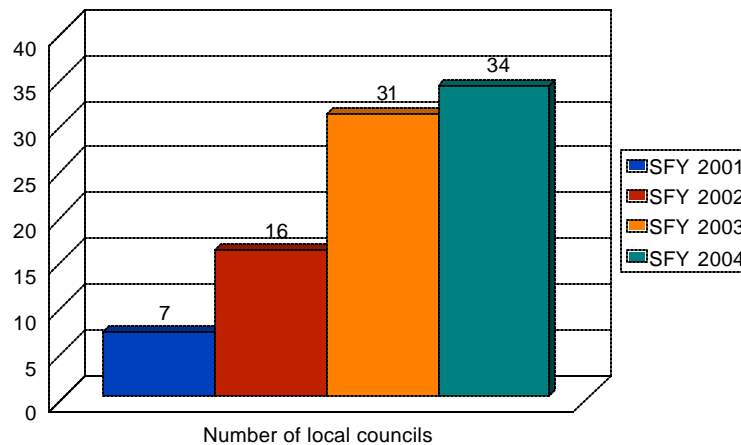
Horseshoe Bend Children’s Resource Team

At a local event on August 28, 2004, Horseshoe Bend kicked off the Horseshoe Bend Children’s Resource Team (Children’s Mental Health Council). The group, containing an elected official, agency representatives, advocates and citizens, has the goal of increasing community awareness for children with serious emotional disturbances. There is now a place for parents to go, with one plan. The new emphasis of this approach is that the parents steer the committee.

Courtesy of Horseshoe Bend News

The rapid growth of councils at the local community level is a clear indicator of the grass roots level support for the system of care philosophy across the state. The support at the local level continues despite the challenges imposed by fluctuating budgets, limited service capacity, and agency constraints.

Number of Local councils



Council Data

Staffings are defined as long term resource planning and coordination with families. Families work directly with council members to develop plans based on the individual strengths of the child and family. Families were also served outside of staffings. These services included family supports, resource library materials, recreational passes, and other services. The table below indicates the number of families served through the councils statewide.

Families Served by Local Councils

	SFY 02	SFY 03	SFY 04
Unduplicated Number of Children/Families Served	(information not available)	(information not available)	197
Unduplicated number of Children/Families Staffed	94	110	145

Idaho Federation of Families for Children's Mental Health

In the past year the Federation (IFFCMH) met several challenges and is moving forward in accomplishing the many needed aspects of family supports and advocacy related to Idaho's System of Care.

The Federation Board of Directors is comprised of family members of youth with SED, mental health and behavioral challenges. We have a youth representative on our Board of directors as well. We would like to expand our board to include a more cultural and ethnic representation of Idaho's population. Anyone interested in being a part of the IFFCMH as a board member can apply online at www.idffcmh.org.

We welcome our new Administrative Director, Ms. Courtney Lester of Spokane, Washington. She will join the Federation team in early December. Our Key Family Contact, Trish Wheeler and the Youth Coordinator, Kathryn Gillenwater have been in place since June 2004. Our Administrative Assistant is Sheila Chee. We are proud to have the skills and assets that these four women add to our organization.

Lisa Rivera is the contract Family Support Specialist (FSS) in Northern Idaho, covering Region 1 and part of Region 2. We are recruiting for family support specialists in the remaining regions of the State and are negotiating funding to cover those positions. We have selected candidates for Regions IV and VI. Extensive training will be provided to all FSS contractors once hired. Support groups in Regions I, III and IV are serving 30 families.

Plans for an on-line Youth Chat Room are in progress. This will be a secure, monitored, weekly chat opportunity for youth ages 12-18. Please contact the IFFCMH office at 208-433-8845 or 1-800-905-3436 for more information or to sign up. The chat room will provide an opportunity for youth across the state, including rural areas to take advantage of educational and anti-stigma programs as well as peer support. Interest levels will provide indicators for the implementation of on-site youth support groups.

Presentations to professionals, other family organizations and various volunteer groups continue to expand the IFFCMH's capacity building efforts. Staff attendance at various state and national conferences improves our skills and knowledge base, which in turn improves the service delivery to families and youth across the state.

This past year the Federation held trainings for families and professionals in all seven regions of the state, and took a key role in many others.

Number of Families participating in “Family Partners – Family Matters” Trainings

Region I	March 24, 2004-	10 parents
Region II	March 25, 2004-	3 parents and 2 youth
Region III	March 30, 2004-	7 parents
Region IV	March 30, 2004-	13 parents and 3 youth
Region V	April 17, 2004-	5 parents and 1 youth
Region VI	May 1, 2004 -	7 parents
Region VII	April 30, 2004-	9 parents

Topics included self and family advocacy, rights, responsibilities and Systems of Care. Representatives from Idaho Parents Unlimited (IPUL), a parent advocacy organization, offered information on supports around Individualized Education Plans (IEP) and school-based challenges. Approximately 150 professionals and agency partners attended these trainings.

Additional trainings, participation in the State Children’s Mental Health conference, statewide video-casts, and other conferences are planned. The efforts of the IFFCMH enabled a number of youth and family members to attend regional, state and national conferences, and to serve on various boards and committees. The Federation is committed to expanding these opportunities to more families and youth across the state as funding becomes available.

The Federation’s focus for the coming year is on moving forward with a spirit of teamwork and integrity to build the organization on many levels. We look forward to hearing from family members, youth, professionals, agency partners and concerned citizens across the state. We want to know how we can better serve the needs of everyone. We look forward to hearing from you.

State Planning Council on Mental Health

The state mental health planning council supports efforts to establish a System of Care for Idaho’s children. Membership consists of consumers and representatives from agencies and advocacy organizations. The council is hopeful that the cooperative agreement will continue to provide technical assistance to the local and regional councils. This will bolster their effectiveness and enhance Idaho’s System of care for children. Despite 23 years of litigation, Idaho still has not fully implemented needed children’s mental health services. The council continues to strongly endorse full implementation of the Jeff D. court plan. Further, we note the significant growth of Medicaid mental health clinical providers and psychosocial rehabilitation providers. We are concerned with little or no oversight to these providers. To that end, we recommend that service utilization management be implemented to assure that state resources are used wisely, concurrent with the Federal Site report.

Seth's Story

It was time for Seth* to leave the detention center and a group home setting seemed like the only option for him. But thanks to the Kellogg Children's Mental Health Council, Seth is thriving at home and in his community.

The probation officer assigned to Seth referred him to the Kellogg Mental Health Council. After listening to Seth's mom, the council came up with a community-based solution: someone to provide in-home care for Seth, as well as therapy for the entire family. The cost for this community-based solution was approximately \$3,000 for three months, instead of \$16,500 for three months in a group home setting.

Seth has progressed beyond in-home treatment. He is enrolled in a public school, as opposed to an off-site, one-on-one setting. Relationships with his father, mother, and siblings have improved. Most importantly, Seth no longer is perceived as a threat to his family or his community.

**name changed*

Agency Reports

Introduction

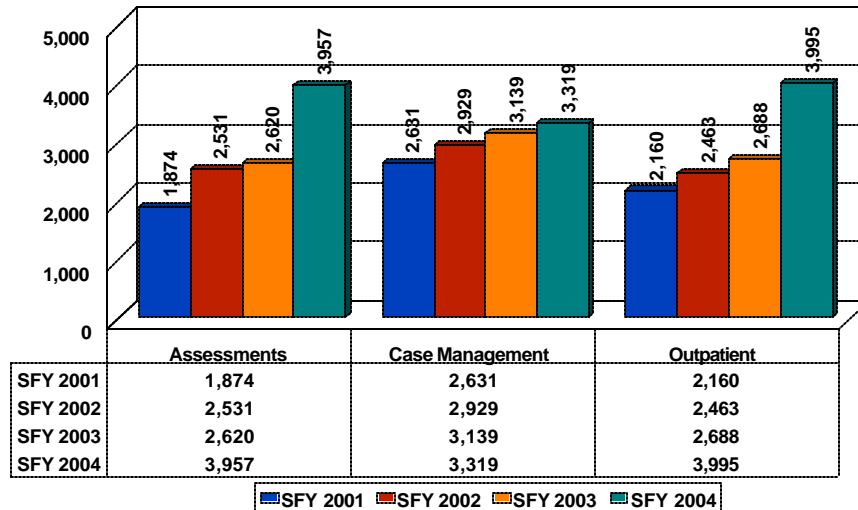
The following agency reports contain information on the array of services, supports and educational opportunities pertaining to children in Idaho. Data was provided by system of care agency partners.

Department of Health and Welfare

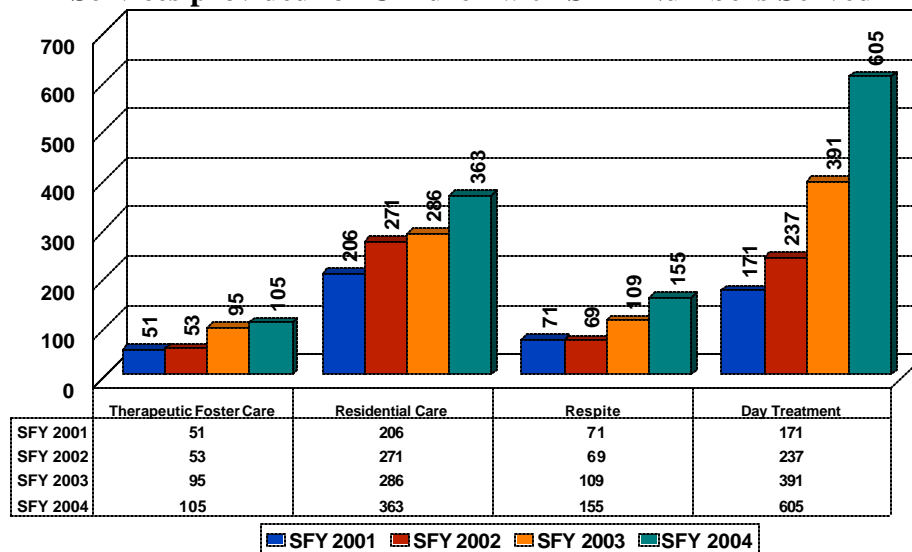
The Department of Health and Welfare provides a continuum of public mental health services to families affected by a serious emotional disturbance (SED) through voluntary agreements with the parents. The Department of Health and Welfare's mental health services are provided through two separate delivery systems, Medicaid and the Mental Health Authority (MHA). Medicaid and the Children's Health Insurance Program (CHIP) offer a variety of outpatient mental health services and inpatient services to individuals qualifying for Medicaid coverage. The Mental Health Authority is the children's mental health program of the Division of Family and Community Services (FACS). Children must meet the Department's definition of serious emotional disturbance which means a diagnosed emotional disorder and a substantial impairment of functioning in major life activities. (See appendix A for the complete definition.)

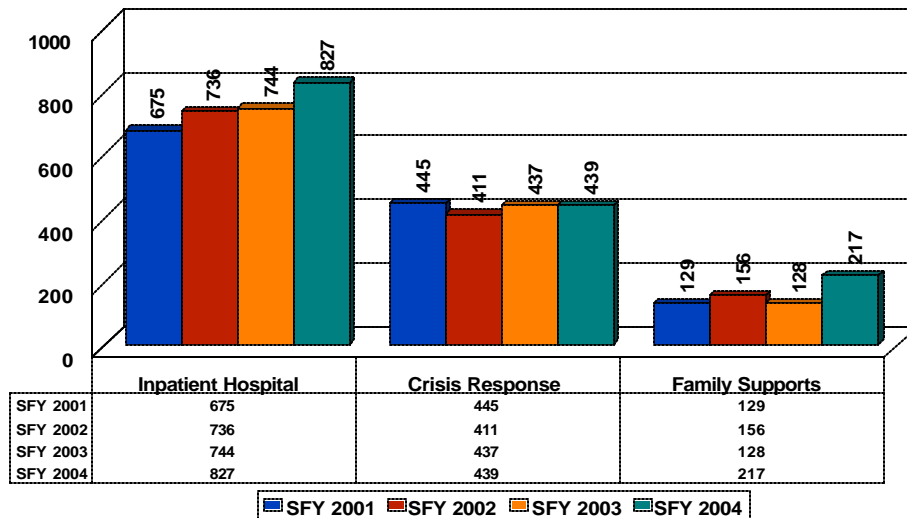
During state fiscal year (SFY) 2003, July 1, 2002 to June 30, 2003, the following children's mental health services were provided to children and families by the Department of Health and Welfare. Due to improvements in data collection, numbers may vary slightly from the 2003 Community Report.

Services Provided for Children with SED -- Numbers Served

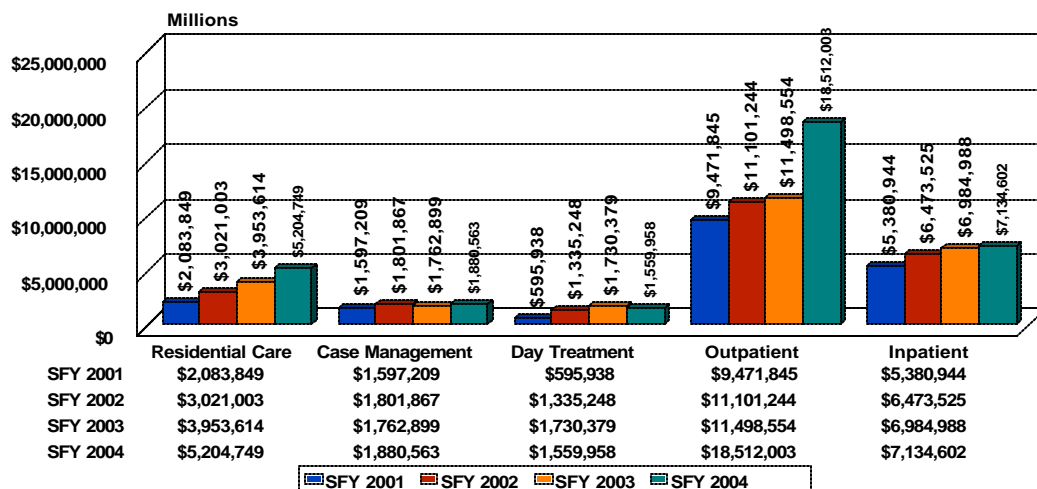


Services provided for Children with SED-Numbers Served

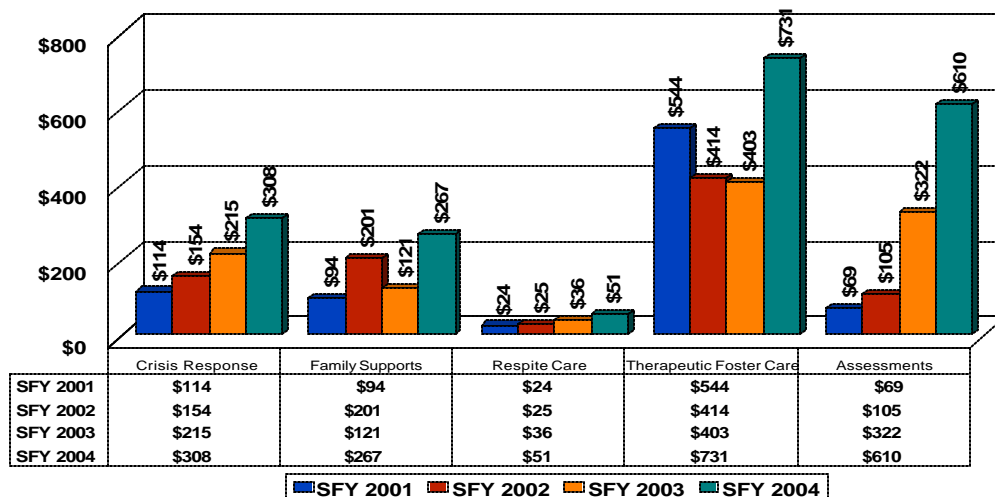




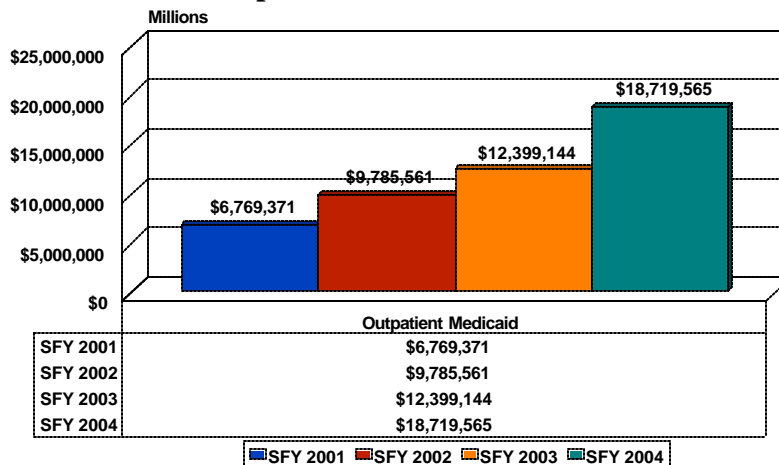
Services Provided to Children with SED-Expenditures



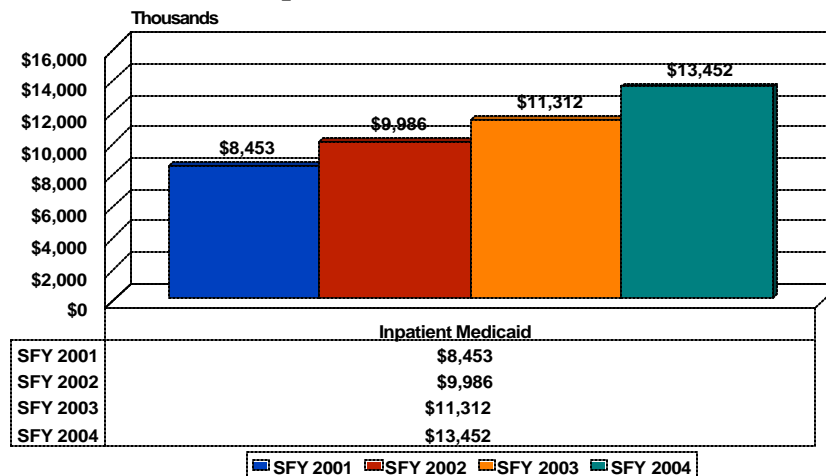
Expenditures for Children with SED



Medicaid Expenditures for Children with SED



Medicaid Expenditures for Children with SED



Definition of Services

Assessment

A comprehensive assessment is defined as the use of the clinical interview, psychometric tools as needed, and pertinent information gathered from the family and community that addresses safety issues, family's /child's concerns, strengths, and natural supports. The assessment is used to determine the child's mental health service needs and identify resources to meet those needs. Additionally, the Department provides suicide risk assessments and mental status exams.

Case Management

Case management is defined as a process for linking and coordinating segments of a service delivery, developing a comprehensive plan for meeting an individual's need for care.

Family Support Services

Family support services are best described as assistance to families to manage the extra stress that accompanies caring for a child with mental health needs. This service is provided to Health and Welfare clients. The main goal of family support services is to strengthen adults in their roles as parents by providing resources for transportation, family preservation services, emergency assistance funds, training, education, or other similar services.

Outpatient Care

Outpatient care is treatment that a child receives in a clinic or community setting designed to decrease distress, psychological symptoms, and maladaptive behavior or to improve adaptive and pro-social functioning. Outpatient care is funded by contracts through the Mental Health Authority and Medicaid. The children receiving services from the Mental Health Authority and the Psychosocial Rehabilitation are determined to have a serious emotional disturbance (SED). Other Medicaid services do not maintain SED as criteria for receiving the service, and therefore, the clinic option services do not reflect only children with SED. Medicaid data includes clinic option services, psychosocial rehabilitation option services, school based mental health services, Early Periodic Screening, Diagnosis, and Treatment Service Coordination and psychiatric services.

Respite Care

Respite services consist of time limited family support services in which an alternate care provider provides supervision and care for a child with mental health needs, either within the family home, residential or group home, or within a licensed foster home.

Day Treatment

Day treatment is a collaborative effort between the Department of Health and Welfare and local school districts to establish structured, intensive treatment in a school or other educational setting. The treatment is aimed primarily at emotional and behavioral interventions, resulting in decreased psychiatric symptoms and increased levels of functioning. It may include a range of services such as companions or tutors to an intensive, self contained classroom setting.

Therapeutic Foster Care

Therapeutic foster care is the temporary care of a child in a licensed foster home that is trained and supported to provide therapeutic 24 hour care for the child. The inclusion of the child's parents in the care and planning is an essential component of therapeutic foster care.

Residential Treatment

Residential care is defined as group homes and treatment facilities that provide 24 hour care for children in a licensed, highly structured setting delivering comprehensive therapeutic interventions.

Inpatient Hospital Care

Inpatient care is defined as services provided within the context of a psychiatric hospital setting. This level of care provides a high level of psychiatric and medical care and is utilized in times of potentially dangerous or high risk situations.

Crisis Response

The primary focus of crisis response services is to resolve emergency situations within the community, including homes, schools, neighborhoods, and hospitals.

Family Satisfaction Surveys

Families receiving children's mental health services from DHW are provided an opportunity every 120 days to anonymously report their perceptions of the services provided. A survey was developed that asks 19 questions regarding access, appropriateness, effectiveness of services received and parental involvement.

Percent Reporting Positively from Family Satisfaction Survey

	SFY 2004	SFY 2003	SFY 2002
Access	95.1%	93.9%	93.1%
Appropriateness	98.5%	97.6%	97.6%
Effectiveness of Services	98.6%	97.5%	97.5%
Parental Involvement	96.9%	95.7%	93.8%

CAFAS Scores of Children Served

The Child and Adolescent Functional Assessment Scale (CAFAS) is a standardized, nationally recognized instrument that measures a child's functioning at school, home and in the community. Scores on the CAFAS range from 0 to 240. An increased score indicates a decrease in functioning. A decreased score means an increase in functioning (Appendix B). A CAFAS score is recorded upon initiation of services, at 120-day intervals, and upon completion of services.

Of the children who received more than one CAFAS assessment, the following percentages are a comparison of the score upon entry into the system versus the most recent score.

Positive change in CAFAS scores

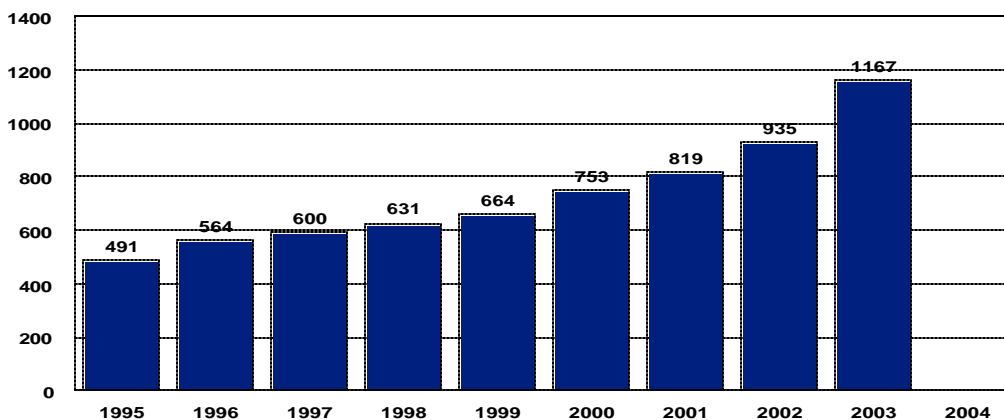
	FY 2002	FY 2003	FY 2004
<i>Percent of children with a positive change in CAFAS score</i>	62%	55%	63%

State Department of Education

The State Department of Education, through local school districts, ensures that eligible students, age 3-21, are provided with an appropriate and individualized education under the Individuals with Disabilities Education Act (IDEA). Students must meet the eligibility requirements for a student with an emotional disturbance under the IDEA.

Data from the December, 2002 Child Count:

Students identified as Emotionally Disturbed (ED)



Numbers of children identified as ED have increased due to the following factors:

1. Increased department directives and trainings on appropriate assessment and intervention for children affected by emotional disturbances for teachers and psychologists.
2. The positive behavioral supports project has increased awareness of appropriate teamwork, assessment, and intervention.
3. IDEA amendments of 1997 identify functional behavioral assessment and intervention for the ED population, and require that they are addressed within individualized educational plans.

Support for Idaho's System of Care

The Department of Education participated in the development of a guidance document to assist DHW and school districts developing day treatment/school based children's mental health contracts. The current effort will result in a more standardized set of core services provided in partnership between DHW and school districts. These changes are slated to be implemented in the 2005-2006 school year. Key improvements include:

- A more equitable model for funding distribution.

- Identifies a set of core services that will be delivered in a self-contained day treatment setting or through a wrap-around support.
- The recognition of Emotional Disturbance as meet criteria for Serious Emotional Disturbance.
- The distribution of a guidance document that will assist DHW regions and school districts in the development of the more standardized contracts.

Preliminary Data from the Positive Behavior Supports Project 2003-04

"Positive behavioral supports" is a project delivering expert consultation to educators. Positive behavioral support teams provide services to students ages three through 21 with significant behavioral disorders or emotional disturbances. This includes appropriate assessments and interventions for students up to three years. The project is funded by the State Department of Education, Bureau of Special education and coordinated by the Center on Disabilities and Human Development at the University of Idaho.

The Table below summarizes the types of disabilities of the children served through the project. Descriptive labels for children served through this project were taken directly from the individual's school district's application. Not all children served had an individual education plan (IEP).

Types of Children Served Positive Behavioral Supports 2003-2004 Academic Year

Age Group	Disability
Preschool/Head Start	Developmental Disability (2)
Elementary	ADHD/ADD (1) Asperger's (3) Autism (12) Cognitive Impairment (1) Developmental Disability (5) Down Syndrome (1) Emotional Disturbance (8) Emotional Impairment (1) Learning Disability (2) Multiple Disability (1) Oppositional Defiant Disorder (1) PDD-NOS (1) SED (1) Traumatic Brain Injury (2)
Junior High/Middle	ADHD/ADD (2) Asperger's (2) Autism (5) Cognitive Impairment (3) Emotional Disturbance (2) Health Impaired - PTSD (2)

Age Group	Disability
	Learning Disability (2)
	OHI-Autism (1)
	TBI (1)
High School	Emotional Disturbance (1)
	Health Impairment (1)
	Learning Disability (2)
	TBI (1)

NOTE: Positive behavioral supports are also providing technical assistance for 5 students with no disability, (3 elementary, and 2 middle schools).

Students with ED who have been suspended or expelled: This data was not disaggregated by disability category last year. Only one district (of 114) suspended a student for over the 10-day limit allowable under IDEA before a functional assessment, behavior intervention plan and alternate educational placement are required. All suspended or expelled students must continue to receive free appropriate public education.

Disputes (complaints, hearings, mediations) involving students with emotional/behavioral problems:

Since July 1, 2003, there have been no disputes for students who are ED or around emotional/behavioral issues.

Services provided to students with ED (total number 1167, Dec. 2003) through an IEP, by number of children receiving the service:

- school psychological services 76
- school social work services 64
- licensed psychologist or psychiatrist 55
- school health 12
- school counseling services 202
- family support (home visits, parent training, counseling) services 49
- one-one aide in a mainstream school environment 49
- vocational services (job coach, placement) 20
- vocational rehabilitation 8
- intensive behavior intervention 75
- one-to-one aide in community placements 14
- Title 1 services 49
- psycho-social rehabilitation 68
- community-based interventions 3
- emotional/behavioral interventions 85
- extended school year 6
- gifted talented 6

Services provided to students in ALL disability categories (total number 29, 094, Dec. 2003) through an IEP, by number of children receiving the service:

➤ school psychological services	154
➤ school social work services	93
➤ licensed psychologist or psychiatrist	61
➤ school health	180
➤ school counseling services	38,405
➤ family support (home visits, parent training, counseling) services	340
➤ one-one aide in a mainstream school environment	626
➤ vocational services (job coach, placement)	215
➤ vocational rehabilitation	131
➤ intensive behavior intervention	209
➤ one-to-one aide in community placements	221
➤ Title 1 services	803
➤ psycho-social rehabilitation	99
➤ community-based interventions	102
➤ emotional/behavioral interventions	201
➤ extended school year	247
➤ number of students/teams provided ongoing consultation through Positive Behavioral Supports Project (on-site, team-based supports)	80

Prevention or interventions for emotional or behavioral concerns:

Training sponsored by the Idaho Department of Education, Safe and Drug Free Schools:

- Student Assistance Teams
- Chemical Awareness Institute (Bullying, Anger Management, Crisis Management)
- Crisis Response Group Facilitator training
- Building Respectful Schools and Classrooms
- Aggression Replacement Training Curriculum
- Youth Leadership Summit
- Asset Building
- Active Behavior Counseling
- Prevention Program for Hispanic youth (literacy and drug/alcohol refusal skills)
- Aggression Replacement Training

Sample Student group participant survey results:

18,954	results received – not all questions were answered
87%	Program had an overall positive effect
61%	Positive effect on school attendance
66%	Positive effect on overall school work
73%	Increased feelings of self worth
79%	Positive ways to deal with problems
87%	Program helped them stay in school (6,548 had considered dropping out of school)
76%	Have stopped or decreased use of tobacco, alcohol or other drugs (4,516 had used tobacco, alcohol or other drugs)

Program Category	Explanation	Participation
Curriculum	Prevention programs implemented and taught in classroom setting during the school day.	412,094
Non-Curriculum	Activities that emphasize and reinforce prevention programs before and after school, and during lunch.	134,628
Peer-Delivered	Youth-led activities such as peer mediation, cross-age teaching, Natural Helpers.	75,981
Special Prevention Events	Assemblies, presentations and activities that reinforce prevention efforts.	282,278
Alternative/Charter Schools	Programs established in alternative school teaching environment, charter schools.	6,996 (Alt = 5,637 <u>Chrtr = 1,359</u>)
Adjudicated (Programs servicing youth in/from Juvenile Corrections)	Prevention programs such as "The Parent Project."	1,922
Parents/Communities	Awareness/educational prevention and parenting skills programs.	40,704
Volunteers	Comprehensive approach costs associated with prevention volunteer activities. 381,320 Volunteer Hours	30,081
Prevention Staff Development	Staff involved in implementing prevention programs, workshops, seminars and trainings.	10,540
Intervention	Services or activities that provide help such as Student Assistance Programs (SAP), drug/alcohol assessments and drug testing, SAP Referrals = 129,603 Drug testing = 8,683 Assessments = 2,509	140,895
Prevention Program Staffing	Prevention program implementation personnel and costs in implementing prevention programs.	615 Personnel providing Prevention Programs with Tobacco Funds

Health Workshops

- Teaching About Mental and Emotional Health: Strategies for the Classroom**
 Students today must deal with a more complicated and stressful world than any past generation. At the same time, because of the material wealth of our country, life for teens is considered by many to be easy and without stress. Many adolescents receive little assistance in dealing with their emotions, yet the decisions they make often have serious consequences. Because of this, students must receive special attention in the area of emotional well-being.

- **Are You Teaching “Thrival” Skills?**

What skills and attitudes do young people need to thrive, not just survive, today and in the future? What do they need to know as they face decisions about sexual behaviors, alcohol and drug use, diet, physical activity, stress management, and related issues? How can caring adults help them develop the perspectives and skills necessary to negotiate a changing world?

- **Idaho Healthy Kids Summit**

Public Awareness Activities: Presentations on the Idaho System of Care and the educational systems:

- Idaho Council on Exceptional Children, October 2003
- School Psychologists: November, 2003
- Elementary School Principals and Special Education Directors, January, 2004
- Idaho Counselor’s Association, January 2004
- Idaho Special Education Directors, May 2004
- Intermountain Hospital Staff presentation, May 2004
- Six hours of educational sessions at the System of Care Conference, May 2004

Department of Juvenile Corrections

The Idaho Department of Juvenile Corrections (DJC) serves youth committed under the Juvenile Corrections Act, for care, control and competency development of judged juvenile offenders. DJC has a legal mandate to provide reasonable medical care, including mental health care, to all juveniles in its custody who have those needs. The Idaho Department of Juvenile Corrections is further identifying juveniles in custody who meet the Department of Health and Welfare's definition of having a serious emotional disturbance (SED). Juveniles with SED constitute only a portion of those in custody who need mental health care, but they are the most seriously ill and most likely to need community-based services upon their return home.

During the last year the number of juveniles committed to the Idaho Department of Juvenile Corrections (DJC) with Serious Emotional Disturbance (SED) has been an average of about 130 or 30% of the DJC population, consistent with the previous year. DJC has been active in several areas to improve the coordination of services to those juveniles, and also to the juveniles with mental health needs in general.

DJC staff participated in local councils. Staff assisted with coordinating services for families and improved role clarification for parents. DJC is sharing mental health costs with DHW for youth in joint custody. Agencies also have worked together to clarify roles of parents in qualifying youth for children's mental health services, and the need for more therapeutic foster care homes.

No other DJC data provided.

APPENDIX A

IDAHO COUNCIL ON CHILDREN'S MENTAL HEALTH

Definition - Serious Emotional Disturbance (SED) for regional and local councils.

A Serious Emotional Disturbance is defined as a child under the age of 18 [or 21 if served by an Individualized Education Program (IEP)], presenting with a diagnosable condition as determined by the DSM-IV or DSM-IV-TR. A substance abuse disorder or developmental disorder, alone, does not constitute a serious emotional disturbance although one or more of these two disorders may co-exist with a serious emotional disorder. Additionally, the child must have a functional impairment that substantially interferes with or limits the child's role or functioning in the family, community or school. The Child and Adolescent Functional Assessment Scale (CAFAS) or the Preschool and Early Childhood Functional Assessment Scale (PECFAS) will measure functional impairment. A score of 80 or above indicates a substantial functional impairment.

NOTE: The adoption of this definition of SED by the ICCMH does not affect an individual agency's definition of SED or an individual agency's criteria for services.

APPENDIX B

DEPARTMENT OF HEALTH AND WELFARE Definition of Serious Emotional Disturbance (SED)

To be eligible for Department of Health and Welfare children's mental health services on an ongoing basis, a child or adolescent must have a serious emotional disturbance characterized by a DSM-IV diagnosis as described below and a functional impairment as described below. A standard clinical assessment will be used to gather and document the information needed to determine if a child has a serious emotional disturbance.

DSM-IV Diagnosis:

An Axis I clinical disorder is required. A substance abuse disorder, conduct disorder, or developmental disorder alone does not by itself constitute a serious emotional disturbance, although one or more of these disorders may co-exist with a serious emotional disturbance. Co-existing conditions require a joint planning process that crosses programs and settings. V Codes are not considered an Axis I disorder for purposes of this definition.

Functional Impairment:

The Child Adolescent Functional Assessment Scale (CAFAS) will be used to determine the degree of functional impairment. The child/adolescent must have a full scale score (using all 8 subscales) of 80 or above with a "moderate" impairment in at least one of the following three scales:

- A. Self-Harmful Behavior
- B. Moods/Emotions
- C. Thinking

NOTE: The Department of Juvenile Corrections also uses this definition to determine if a youth is seriously emotionally disturbed.

APPENDIX C

STATE DEPARTMENT OF EDUCATION Definition of Emotional Disturbance (ED)

A student with emotional disturbance has a condition exhibiting one or more of the five behavioral or emotional characteristics over a long period of time, and to a marked degree, that adversely affects his or her educational performance. The five behavioral or emotional characteristics include:

1. An inability to learn that cannot be explained by intellectual, sensory, or health factors;
2. An inability to build or maintain satisfactory interpersonal relationships with peers and teachers;
3. Inappropriate types of feelings under normal circumstances;
4. A general pervasive mood of unhappiness or depression; or
5. A tendency to develop physical symptoms or fears associated with personal or school problems.

APPENDIX D

COMMONLY USED ACRONYMS

CMH:	Children's Mental Health
DHW:	Department of Health and Welfare
DJC:	Department of Juvenile Corrections
SDE:	State Department of Education
CMHSA:	Children's Mental Health Services Act
ED:	Emotional Disturbance
IDEA:	Individuals with Disabilities Education Act
SED:	Serious Emotional Disturbance
CAFAS:	Child Adolescent Functional Assessment Scale
PSR:	Psychosocial Rehabilitation Services
IEP:	Individual Education Program
RMHA:	Regional Mental Health Authority
DAG:	Deputy Attorney General
MOA:	Memorandum of Agreement
HIPAA:	Health Insurance Portability and Accountability Act
EPSDT:	Early and Periodic Screening Diagnosis and Treatment
IBI:	Intensive Behavioral Interventions
MHA:	Mental Health Authority (DHW/CMH Program)
SOC:	System of Care